



BUREAU TALK

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NEW FACES ☺

The bureau is pleased to announce that beginning February 1, 2008, Janissa Moore will be joining the bureau staff as an office support assistant. Janissa will be taking the position previously held by Emily Bruce. Emily recently took another position within the department, as a senior office support assistant, which resulted in a promotion. While Emily will be missed, we are happy to have Janissa join our staff. She is a very charismatic young lady and will bring much enthusiasm to the bureau! Please join us in welcoming Janissa!

PSYCHIATRIC NURSING

The question, "What are the required qualifications of a psychiatric nurse?" has been asked of our bureau several times over the last few months. Information has been published in past Bureau Talks (2001, 2002) regarding the qualifications for a psychiatric nurse; however, the latest guidance available on this subject can be found in the Medicare Benefit Policy Manual, Chapter 7 – Home Health Services, Section 40.1.2.15. The section is titled, "Psychiatric Evaluation, Therapy, and Teaching." Although the manual was last revised 08-12-05, this particular section was last updated 10-01-03. It states, " Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse."

FAMILY CARE SAFETY REGISTRY

The Family Care Safety Registry Unit has asked that the bureau once again publish a reminder to agencies regarding the on-line registration that is available.

Submit your worker registration using the Internet. If you take advantage of this service you will be charged a nonrefundable registration fee plus a \$1.00 processing fee for each registration submitted. For more information go to <http://dhss.mo.gov/fcsr>. NOTE: You will continue to have the option to submit the Worker Registration by mail.

FAMILY CARE SAFETY REGISTRY Cont.

If you have questions, please call the toll-free access line 1-866-422-6872, 7:00 a.m. to 6:00 p.m., Monday through Friday.

CLARIFICATION ON CRIMINAL BACKGROUND CHECKS

In the last Bureau Talk, dated October 2007, the bureau made a statement, “ Per section 660.317 (3) (1) RSMo...If the applicant has not resided in this state for 5 consecutive years prior to the date of his/her application for employment, the provider shall request a nation-wide check for the purpose of determining if the applicant has a prior criminal history in another state...”

Since this publication, the bu-

reau has received a clarification on this issue. Section 660.317 (4) states “State funding and the obligation of a provider to obtain a nationwide criminal background check shall be **subject to the availability of appropriations.**” Appropriations have not yet been allocated for this purpose; therefore, this portion of the statute has not been implemented in the state of Missouri. Therefore, the bureau is retracting the information previously

published in the October 2007 Bureau Talk.

The bureau would like to remind all agencies that employers are ultimately responsible for making their own employment decisions and should always use due diligence when verifying information regarding out-of-state offenses or findings self reported by the applicant or reported to them by another source

ANNUAL STATISTICAL REPORTS

This is just a reminder that all annual statistical report forms were due January 31, 2008. Any agency that has not submitted their statistical report by the due date is subject to citation.

STAMPED PHYSICIAN SIGNATURES

CMS Transmittal 220, Change Request 5550 was published August 24, 2007. This change request outlined CMS Program and Integrity Manual Revisions. One of the changes involves Section 3.4.1.1 (B) of the Program & Integrity Manual titled “Signature Requirements”. (The information in “red” indicates the changes that have been made). It states,

“3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

B. Signature Requirements

Medicare requires a legible identifier for services provided/ordered. The method used **may be** hand written **or an** electronic signature to sign an order or other medical record documentation for medical review purposes. **Therefore**, a signature in some form, needs to be present. Do not deny a claim on the sole basis of type of signature submitted.

STAMPED PHYSICIAN SIGNATURES Cont.

Noted Exception: Signature(s) of the physician(s) must be written on the certifications of terminal illness for hospice.

Providers using alternative signature methods (electronic systems) should recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All State licensure and State practice regulations continue to apply. Where State law is more restrictive than Medicare, the contractor needs to apply the State law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

Note that this instruction does not supersede the prohibition for Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs). CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) have been met."

As you can see from the above excerpt from the Program & Integrity Manual, removed was the language that stamped signatures was acceptable. CMS is aware that this contradicts the Conditions of Participation, which does allow stamped signatures. CMS stated on a recent "All State Call" that they are working with the Program Integrity Unit on this issue. The State Operations Manual and the Interpretive Guidelines will have to be eventually changed to coincide with this revision. However, at this time, state surveyors are instructed to continue to accept stamped signatures, but to make agencies aware that, if billing for a Medicare patient, the claim may very well be denied by the fiscal intermediary.

SHOW ME HOME CARE AND REHAB

At previous conferences/teleconferences, Lisa Coots, Administrator, announced that the bureau would soon provide for public viewing, through the bureau's internet web site, the most recent survey of all entities regulated by our bureau. This website would publish any findings of deficiencies and the agency's proposed plan of correction. The name of the website will be called "Show Me Home Care and Rehab".

Unfortunately, due to technical delays the completion date for getting the website up and running has been delayed until April of 2008.

News from the MOO arena...



OASIS Training

Hopefully, by now you have already signed up for the OASIS training that is being offered by the Bureau of Home Care over the next couple of months. A notice regarding this training was sent via e-mail to all home health administrators. This training is free and the training is coming to your area! We are trying to make it as easy as possible for each home health agency to have access to OASIS training. If you have not registered, please do so soon by using the on-line registration form. The form and all the locations and times of the trainings can be found at http://www.dhss.mo.gov/OASIS_Training.html.

Please note: The registration form indicates the registration is limited to 3 people per agency; however, at this time, please feel free to register as many nurses as you wish to whatever location is most convenient.

OASIS Start of Care Date

In June of 2006, revisions to Chapter 8 of the OASIS Implementation Manual, redefined the Start of Care (SOC) date to be the day of the first skilled visit. The revisions substituted "skilled" for "reimbursable". Per CMS, the change in language found on page 8.18 of the June 2006 revisions where the word "reimbursable" was replaced with "skilled" was unintentional. Providers are instructed to continue to define the **Start of Care as the date the covered or reimbursable service is provided.**

With the other new changes in OASIS due to the implementation of PPS 2008, CMS has made a clarification. CMS Q & A, Category 2, Question 36 clarifies what the definition of start of care is. **"Start of care relates to the 'first billable visit.'** The 'first billable visit' approach was selected largely because of the Medicare payment requirements and the fact that the first billable visit defines SOC and the start of the episode for Medicare purposes." Recent instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services), does state that now, even for Medicare, the first billable visit might be a visit made by a home health aide, once the need and eligibility has been established.